Commonwealth of Virginia

State Health Benefits Program Enrollment Form

For Retirees, Survivors And LTD Participants–Special January 1, 2006 Version

EXISTING MEDICARE-COORDINATING PLAN MEMBERS SHOULD USE THIS FORM TO:

- Make an allowable plan change to be effective **January 1, 2006**; and/or,
- Report your Medicare Claim Number if it is anything other than your Social Security Number and the letter "A" (for example, if your Medicare Claim Number is 999-99-9999-HA, 999-99-9999-B, etc.).

This form should be received by November 30, 2005, to ensure accurate information for January 1, 2006. **See reverse for information on where to send your completed form.**

DO NOT USE THIS FORM IF:

- You wish to make an allowable plan change to be effective later than January 1, 2006;
- You are a new Medicare-eligible program participant;
- You wish to make a change due to a qualifying mid-year event;
- You are not eligible for Medicare.

In the above cases, use enrollment form #T20470. (Available from your Benefits Administrator or at www.dhrm.virginia.gov.)

IF YOU ARE SUBMITTING THIS FORM TO REPORT YOUR MEDICARE CLAIM NUMBER, PLEASE COMPLETE THE FOLLOWING: *(This information is only required if your Medicare Claim Number is anything other than your Social Security Number with an "A" at the end.)*

Name of Covered Participant: _____

Current ID Number (on your current health plan ID card): _____

Medicare Claim No. (on your red, white and blue Medicare Health Insurance Card): _____

IF YOU ARE SUBMITTING THIS FORM TO MAKE A PLAN CHANGE TO BE EFFECTIVE JANUARY 1, 2006, PLEASE COMPLETE THE FOLLOWING:

Print Name of Enrollee (Retiree, Survivor or LTD Participant): _____

Current ID Number: _____

If this change is for a covered dependent in a Medicare-coordinating plan with individual coverage, please list the dependent's name below:

Dependent's Name: _____ Current ID Number: _____

Enrollee's Address: _____

Phone: _____ E-Mail Address: _____

I wish to make the following plan election. I understand that my form should be received by November 30, 2005, to ensure accurate information for January 1, 2006. (Please consult your rate notification package for additional information.)

☐ **Advantage 65** (includes prescription drug coverage)
☐ **Advantage 65 + Dental and Vision** (includes prescription drug coverage)
☐ **Medicare Complementary/Option I** (includes prescription drug coverage)
☐ **Medicare Supplemental/Option II** (includes prescription drug coverage)
☐ **Medicare Supplemental/Option II + Dental and Vision** (includes prescription drug coverage)
☐ NEW! **Advantage 65 – Medical Only** (does not include prescription drug coverage)
☐ NEW! **Advantage 65 – Medical Only + Dental and Vision** (does not include prescription drug coverage)
☐ **Cancel Coverage**

(continued on reverse)

ENROLLEE STATEMENT: I am a current participant in the State Retiree Health Benefits Program, and I wish to make the plan change indicated on page 1 (reverse). I understand that my premium will either be deducted from my monthly Virginia Retirement System (VRS) retirement payment or, if I do not receive a VRS retirement payment or my VRS retirement payment will not support the deduction of my premium payment, billed by the Commonwealth of Virginia billing administrator. I understand that if I cancel my coverage, I will not have the opportunity to return to the program at any time and that my cancellation will result in the cancellation of any dependents covered based on my eligibility. I understand that election of the Advantage 65–Medical Only Plans precludes my future enrollment for prescription drug coverage under the program. I understand that my health benefits premium is subject to change. I am aware that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that failure to pay premiums by the date designated on my monthly bill, if applicable, will result in cancellation of coverage and will permanently revoke my eligibility for the program. Further, I understand that no claims will be processed for services during months for which premium payment in full has not been received. I understand that enrolling or maintaining coverage for ineligible dependents may result in removal from the program for up to three years.

CERTIFICATION/AUTHORIZATION: I certify that I have a reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Enrollee's Signature* _____ Date: _____

**Dependents are not authorized to sign this form. It must be signed by the Retiree, Survivor or LTD participant.*

SEND COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR DESIGNATED BELOW:

IF YOU ARE:	SEND TO:
• A current Virginia Retirement System (VRS) Retiree or Survivor (or a covered dependent of a VRS retiree or survivor)	Virginia Retirement System P. O. Box 2500 Richmond, VA 23218-2500
• A current Virginia Sickness and Disability Program (VSDP) Long-Term Disability (LTD) Participant (or a covered dependent of a VSDP LTD participant)	Virginia Retirement System P. O. Box 2500 Richmond, VA 23218-2500
• An Optional Retirement Plan (ORP) Retiree, Local Retiree, or non-VSDP Long-Term Disability Plan participant (or a covered dependent of an ORP Retiree, Local Retiree, or non-VSDP LTD participant)	Your pre-retirement agency Benefits Administrator

VRS USE ONLY

Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____